STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

October 12, 2007

GENERAL LETTER NO. 3-G-1

ISSUED BY: Division of Field Operations

SUBJECT: Employees' Manual, Title 3, Chapter G, ***MEDICAID FALSE CLAIM POLICY***, Title page, new; Contents (page 1), new; and pages 1 through 11, new.

Summary

This new chapter provides guidelines to the Division's facilities that receive Medicaid funding, for the detecting and preventing fraud, waste, and abuse of Medicaid funds.

All employees are prohibited from knowingly making false Medicaid claims. The facilities are required to implement systems for monitoring Medicaid claims, payments, and documentation of services funded under Medicaid.

Employees are required to report knowledge of, suspicion of, or awareness of alleged Medicaid false claims. Employees may also report their knowledge, suspicion, or awareness of false claims to public officials.

Effective Date

Immediately.

Material Superseded

None.

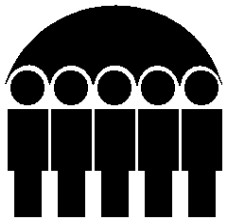
Additional Information

Refer questions about this general letter to the office of the deputy director for field operations.

October 12, 2007

Employees' Manual
Title 3
Chapter G

Medicaid False Claim Policy



Iowa
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General Principles

Legal reference: Public Law 109-171, Deficit Reduction Act of 2005, Sec. 6032

It is the policy of the Department that all claims for payment made to the Medicaid program shall only be for services authorized for payment and services actually rendered. Each facility that is authorized to file claims with Medicaid shall have policies and procedures in place that assure that only legitimate claims are filled and for monitoring the claims process to assure that only proper claims are filed.

The Department does not condone and will not tolerate the filing of fraudulent claims of any nature. All claims for payment submitted for payment to the Medicaid Program shall be appropriate and legal.

Employees, contractors, and subcontractors shall be aware of this policy and the requirement to report allegations of false claims or misrepresentation. All allegations of false claims or misrepresentation shall be immediately and thoroughly investigated.

Management is responsible monitoring the claims process to assure that fraudulent claims shall not be submitted. Claim billing procedures are regularly monitored and reviewed to assure that all billings shall be legal.

When improper claims, false claims, or misrepresentations occur, immediate action shall be taken to correct the improper claims and to implement necessary system corrections to prevent future improper claims.

Policies for Detecting and Preventing Fraud, Waste, and Abuse

The state mental health institutes and resource centers shall have policies and procedures in place to assure that:

- Employees, contractors, and subcontractors shall be prohibited from knowingly making a false statement or misrepresentations of material facts or knowingly and deliberately failing to disclose material facts in a claim for Medicaid payment for services or merchandise rendered or purportedly rendered.
- All employees, contractors, and subcontractors shall be informed of the laws pertaining to the filing of Medicaid claims and this policy.
- Facility fiscal management policies and procedures shall provide for checks and balances to detect fraud, misrepresentation, and misapplication of Medicaid claim billing procedures.

- All employees, contractors, and subcontractors shall be required to report to management any suspicion or allegations of false Medicaid claims or misrepresentation without fear of reprisal and shall be provided with the whistleblower protections in federal and state laws.
- The policies and procedures in this chapter shall provide a guide for the filing of payment claims to any other state, county, or federal agency.

Reporting Allegations of Fraud or Misrepresentation

Mental health institute and state resource center policies and procedures shall assure that:

- Employees, contractors, and subcontractors shall be required to immediately report any knowledge, suspicion, or awareness of an alleged Medicaid false claim or misrepresentation to the superintendent or the superintendent's designee.
- The superintendent or the superintendent's designee shall immediately report the allegation to the deputy director of Field Operations and to the administrator of the Division of Fiscal Management.
- An employee, contractor, or subcontractor shall have the right to report any knowledge, suspicion, or awareness of a Medicaid false claim or misrepresentation to a member or staff of the General Assembly, other public official, or law enforcement agency if the employee, contractor, or subcontractor reasonably believes a Medicaid false claim or misrepresentation has occurred.

  The employee, contractor, or subcontractor may make the report without informing the Department of that report unless the employee, contractor, or subcontractor represents the disclosure as the official position of the Department.

Division Actions

When any allegation of Medicaid fraud or misrepresentation is reported, the Division of Field Operations shall assure that:

- Immediate notice shall be given to the Department administrator and the administrator of the Division of Fiscal Management.
- Immediate notice shall be given to the administrator of the Division of Medical Services.
- A Division employee shall be assigned to assure that:
  - Facility staff make a fair and impartial investigation of the allegation; and
  - Proper corrective actions are developed and implemented.

Case/Medical Records Review

Mental health institute and state resource center policies and procedures shall assure that:

- A proper case/medical record system shall be in place to collect and document the information required on services provided to support all claims, as required, for Medicaid payments.
- A random monthly sample shall be selected, equal to 5% of all current active case/medical records of all individuals receiving services funded in whole or in part by Medicaid.
- The sample shall be reviewed to determine if the Medicaid required documentation of services in the record supports the Medicaid claim filed for that individual.

  "Record" is defined as any part of the facility's case/medical record or records for an individual that is used to record the services, activities, or treatments funded in whole or in part through the Medicaid program.
- The review shall be under the direction and supervision of the superintendent or the superintendent's designee, who shall:
  - Select the sample of records to be reviewed;
  - Select the employee to do the review;
  - Assure that all reviews are completed by the 15th working day of each month; and
  - Receive the report of the review as soon as each review is completed.
- The review shall be conducted by an employee who:
  - Has been trained on what documentation is required; and
  - Has not been responsible for providing the documentation being reviewed.
- The findings of the review shall be documented in writing indicating:
  - The number of records reviewed,
  - The facility unique identifier number of the record reviewed,
  - The date of the review, the specific program areas reviewed,
  - The employee responsible for documenting the service,
  - Whether or not the review found the record compliant, and
  - If the record was not compliant, a detailed explanation of the non-compliance, including an evaluation as to whether the non-compliance may have been the result of a fraudulent action.

- The superintendent or the superintendent's designee shall:
  - Prepare a report of the findings of each month's reviews and
  - Submit the report to the deputy director for field operations by the fifth working day of the following month.

Corrective Action

Mental health institute and state resource center policies and procedures shall assure that:

- If a non-compliant record is found, the superintendent or the superintendent's designee, shall implement appropriate corrective action with the Medicaid program.
- If a non-compliant record is found that may be the result of fraudulent actions, the superintendent or the superintendent's designee, when the superintendent or designee becomes aware of the non-compliance, shall report that finding to the deputy director of field operations within two hours.
- Within five working days of a report of non-compliance, the superintendent or the superintendent's designee shall develop a corrective action plan to correct the deficiency in that individual case. The plan shall also address if personnel action is required or not required. In either case, information shall be included to support that decision.
- For any program area in which a deficiency is found, a 25% sample shall be pulled of the records in that program area and reviewed.
- If any additional deficiencies are found, the deputy director for field operations shall be contacted to develop a plan for further review and corrective action.

Fiscal Management Review

Mental health institute and state resource center policies and procedures shall assure that:

- An accounting system shall be in place that shall provide accurate and sufficient detail to track all claims filed for Medicaid payment and receipt of Medicaid payments.
- Financial management practices and procedures shall provide for a complete and thorough system of checks and balances to reduce or eliminate opportunities for the filing of fraudulent claims or making misrepresentations in Medicaid payment claims.

- At **state resource centers**, practices and procedures shall include but are not limited to the following:
  - Before submittal, all Medicaid billing claims prepared shall be reviewed to assure that the census data on client days and the claimed amount are correct for each individual for whom a claim is submitted. This review shall be conducted by:
    - At least one employee of the state resource center's business office, and
    - At least one other employee other than the employee who prepared the claim.
  - The business manager or the business manager's designee shall authorize the claim by signing the claim before submittal. The designee shall be an employee other than the employees who initially reviewed and prepared the billing claim.
  - A final reconciliation of all claims shall be done when payment for the claim is received. The reconciliation shall be done by at least two employees from the state resource center's business office and shall review the payment received to determine that:
    - The amount received is correct,
    - The number of patient days paid is correct, and
    - The amount of client participation deducted is correct.
- At **mental health institutes**, practices and procedures shall include but are not limited to the following:
  - Before submittal, all Medicaid billing claims shall:
    - Have the eligibility of the individual confirmed by calling the REVS line.
    - Have the number of days certified checked against the written certification.
    - Have the number of days to bill shall be checked against the daily or weekly census reports. At least two separate employees shall be involved in independently checking the number of days billed on a claim.
    - Have any ancillary services included in the claim checked for accuracy.
  - When payment for the claim is received, a final reconciliation of all claims shall be done by at least two employees from the mental health institute's business office. The employees shall review the payment received to determine that
    - The amount received is correct, and
    - The number of patient days paid is correct.

- All facilities shall select a random monthly sample equal to 5%of the claims filed for payment in the previous month for detailed review. The sample claims shall be reviewed to determine:
  - If the individual for whom a claim was filed was Medicaid-eligible;
  - If the claim was for the proper amount;
  - If the claim was properly filed; and
  - If the claim may have been fraudulently filed.
- The review shall be under the direction and supervision of the superintendent or the superintendent's designee who shall:
  - Select the sample of claims to be reviewed;
  - Select the employee to do the review;
  - Assure that all reviews are completed by the 15th working day of each month; and
  - Receive the report of the review as soon as each review is completed.
- The review shall be conducted by an employee who:
  - Has been trained on the claim requirements, and
  - Has not been responsible for filing the claim or receipt of the payment being reviewed.
- The findings of the claims review shall be documented in writing indicating:
  - The number of records reviewed,
  - The facility unique identifier number of the claim reviewed,
  - The date of the review,
  - The employee responsible for documenting the filing of the claim,
  - Whether or not the review found the claim compliant, and
  - If the claim was not compliant, a detailed explanation of the non-compliance including an evaluation as to whether or not the non-compliant claim may have been as the result of fraudulent action.
- The superintendent or the superintendent's designee shall:
  - Prepare a report of the findings of each month's reviews and
  - Submit the report to the deputy director for field operations by the fifth working day of the following month.

Corrective Action

Mental health institute and state resource center policies and procedures shall assure that:

- If a non-compliant claim is found, the superintendent or the superintendent's designee shall implement appropriate corrective action with the Medicaid program.
- If a non-compliant claim is found that may be the result of fraudulent actions, the superintendent or the superintendent's designee shall, when the superintendent or designee becomes aware of the non-compliance, report that finding to the deputy director of field operations within two hours.
- Within five working days of a report of non-compliance, the superintendent or the superintendent's designee shall develop a corrective action plan to correct the deficiency in the claim. The plan shall also address if personnel action is required or not required. In either case, information shall be included to support that decision.
- For any month in which a deficiency is found, a 25% sample shall be pulled of the claims for the month and reviewed.
- If any additional deficiencies are found, the deputy director for field operations shall be contacted to develop a plan for further review and corrective action.
- An audit by the state auditor shall be performed no less frequently than annually of Medicaid claims. A superintendent or the deputy director for field operations may request the state auditor to perform an audit at any time.
- All employees, contractors, or subcontractors shall provide all information requested and cooperate fully with any review or audit.

Personnel Practices

Mental health institute and state resource center policies and procedures shall assure that:

- Before beginning employment or changing jobs within the facility, all employees, contractors, and subcontractors shall be checked to determine whether or not they are on the federal Excluded Parties List (EPL). The findings shall be documented in the individual's employment record in a manner that permits the information to be available individually and in aggregate form.

- Before beginning employment, all employees, contractors, and subcontractors shall be notified of the laws governing Medicaid fraud including:
  - The requirements of the Federal False Claims Act established in Title 31, Chapter 38, of the United States Code;
  - The administrative remedies for submitting false claims and statements established in Title 31, Chapter 38, of the United States Code;
  - The civil and criminal penalties for knowingly submitting false claims or making false statements established in Title 31, Chapter 38, of the United States Code;
  - The whistle blower protections provided under federal and state laws; and the mental health institute's or state resource center's policies and procedures for detecting and preventing fraud, waste, and abuse.
- All employees, contractors, and subcontractors shall be required to sign unnumbered form, *Department of Human Services Briefing Sheet,* to signify that they have received notification of the laws governing Medicaid fraud. The signed form shall be retained the personnel files of the institution.
- Any employee, contractor, or subcontractor who, in good faith, makes an allegation of Medicaid false claim fraud or misrepresentation shall be offered protection from retaliation or harm as provided in the section Iowa Code section70A.28 and Title 31, subsection 3730(h), United States Code. (See Whistle Blower Protections.)
- Any employee, contractor, or subcontractor who has been found to have submitted a false Medicaid claim or made false representation relating to a Medicaid claim shall be subject to sanctions, up to and including dismissal or termination of contract.
- Any employee, contractor, or subcontractor who fails to report knowledge, suspicion, or awareness of any allegation of false Medicaid claim or misrepresentation to the superintendent or the superintendent's designee shall be subject to sanctions, up to and including dismissal or termination of contract.
- All decisions on type and severity of disciplinary actions taken against any employee shall be done timely and shall be based on an evaluation of:
  - The type and severity of the incident based on the evidence contained in the report of the investigation,
  - Prior personnel actions taken with the employee, and
  - Other components of just cause.

Claim Performance Improvement

Mental health institute and state resource center policies and procedures shall assure that the facility's management employees have in place quality management practices to:

- Monitor the implementation and operation of the Medicaid claim process.
- Review the findings of the review processes for records, filed claims, and payment receipts to assure that the system is implemented as required in this policy.
- Review the combined findings of the separate reviews to identify broader systemic problems or issues needing corrective action, whether actual or potential.
- Develop corrective action plans to address identified problems or issues.
- Monitor the completion and implementation of corrective action plans.

Employee, Contractor and Subcontractor Training

Mental health institute and state resource center policies and procedures shall assure that:

- All employees, contractors, and subcontractors shall be trained in general knowledge about the Medicaid claim billing process including:
  - This policy including the review process to be used to monitor the accuracy of supporting documentation, claims filed and payments received;
  - The services provided by the facility that are eligible for payment through Medicaid;
  - The process for reporting any suspected Medicaid false claims or misrepresentation; and
  - Protections provided by the state and federal laws covering whistleblowers.
- All employees, contractors, and subcontractors responsible for documenting services provided for which reimbursement is sought shall be trained in proper documentation.
- All employees, contractors, and subcontractors responsible for preparing and filing claims for payment shall be trained in the proper preparation and filing of claims.

- All employees, contractors, and subcontractors responsible for monitoring the claims process shall be trained in the proper procedures for monitoring Medicaid claims.
- All training shall be regularly documented in a manner that permits the information to be available individually and in aggregate form.
- Training curriculum shall be updated regularly to reflect current Medicaid claims policies and procedures, facility policies and procedures, and changes in services eligible for Medicaid payment.
- Training shall be implemented in a timely manner.

Laws Relating to Detecting and Preventing Fraud, Waste and Abuse

Federal laws relating to detecting and preventing Medicaid fraud, waste, and abuse are found in Title 31 of the United States Code, as follows:

- Sections 3729-3733 are known as the False Claims Act, which provides for significant damages against persons who knowingly present false or fraudulent claims to the U.S. government for payment or approval or who conspire to defraud the government. The damages assessed can range from $5,000 to $10,000 plus three times the amount of damages sustained by the government.

  A copy of this law can be found at:
  http://www4.law.cornell.edu/uscode/html/uscode31/usc_sec_31_00003729----000-.html

- Sections 3801-3812 authorize federal administrative authorities to assess a civil money penalty of $5,000 per claim plus an assessment of twice the amount of the claim against persons who submit false, fictitious, or fraudulent claims. A copy of this law can be found at:
  http://www4.law.cornell.edu/uscode/html/uscode31usc_sec_31_00003801----000-.html

State law relating to detecting and preventing Medicaid fraud, waste, and abuse includes Iowa Code Section 249A.7, which provides that:

> "A person who obtains assistance or payments for medical assistance under this chapter by knowingly making or causing to be made, a false statement or a misrepresentation of a material fact or by knowingly failing to disclose a material fact required of an applicant for aid under the provisions of this chapter and a person who knowingly makes or causes to be made, a false statement or a misrepresentation of a material fact or knowingly fails to disclose a material fact, concerning the applicant's eligibility for aid under this chapter commits a fraudulent practice."

A copy of this law can be found at: http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=IowaCode&input=249A.7

Whistle Blower Protections

Federal laws relating to whistle blower protection is found in Title 31 of the United States Code, section 3730(h), which specifies the federal protections provided to an employee who:

- Lawfully participates in a federal false claims act case; and
- Is discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against.

Employees have the right to pursue a cause of action in federal district court for reinstatement, back pay, special damages and costs and attorney fees.

A copy of this law can be found at: http://www4.law.cornell.edu/uscode/html/uscode31/usc_31_00003730----000-.html

State law relating to detecting and preventing Medicaid fraud, waste, and abuse includes Iowa Code Section 70A.28, which provides protections to state of Iowa employees who disclose information the employee reasonably believes is evidence of "a violation of law or rule, mismanagement, a gross abuse of funds, an abuse of authority or a substantial and specific danger to public health or safety."

Protected disclosures can be made to a member or employee of the state legislature, the office of citizens' aid, a public official, or a law enforcement agency. This law is commonly known as the State's "whistle blower" law. A copy of this law can be found at: http://coolice.legis.state.ia.us/Cool-ICE/default.asp?category=billinfo&service=IowaCode&input=70A.28